Attachment: Public Input and Responses to Previous Year's Grant Recommendations

Public Input

An abridged draft of the FFY 2006 Application/Report, including data tables, was posted on the MCAH/OFP Branch website for review and comment. MCAH/OFP partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft.

The CMS Branch updated the Title V link on the CMS website to indicate that a preliminary draft of the 2006 Application/Report was posted on the MCAH/OFP website and the website address was given. A CMS Information Notice was posted to the CMS website informing viewers about the MCAH/OFP website, the CMS Title V link, and to whom to send comments following review of the draft. Notification of the posting of the CMS Information Notice went to all County California Children's Services (CCS) Administrators, Child Health and Disability Prevention (CHDP) Program Directors and Deputy Directors, County CCS Medical Consultants, State CMS Branch Staff and State Regional Office Staff. CMS notified the Branch's diverse group of stakeholders (44 individuals), including representatives of state technical advisory committees, American Academy of Pediatrics, hospital associations, pediatric provider groups, state departments and agencies, Regional Centers, Family Voices, Protection and Advocacy, and parents, for comments on the draft. These stakeholders were encouraged to share the document with their colleagues. CHDP Subcommittee Chairs were also notified of the document and comments requested from them and their colleagues.

Several comments were received indicating that the document looked fine and that it appeared that a lot of work had gone into producing it. Other comments included the following:

Comment 01

I notice that some parts of the application mentioned some of the work done by counties. I wonder why other counties' work was not included. For example, in the section on "Eliminating racial and ethnic disparities in health," it mentions Contra Costa County. In Solano County we have done similar work and have developed our own "Back to Sleep Campaign" and materials "Your Baby Matters" in English and Spanish and posters that target African American and Latino populations. Under section, "Fetal Alcohol Spectrum Disorder," again some counties are mentioned. In Solano we were awarded from First Five Solano Children and Families Commission 1.7 million dollars to decrease the infant mortality rate, rate of low birth weight infants and long term impacts on children and systems of care in Solano County by identifying and addressing prenatal substance use among women at risk of or identified as using alcohol, tobacco, or other drugs.

Response to Comment 01: Title V is administered by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. HRSA is very specific in its requirements for the annual Title V block grant report/application, including maximum length limits for each section of the report. The HRSA length limits do not allow us to include descriptions of all relevant projects at the local level. However, in this case, we have added a mention of Solano County in Section III A Major State Initiatives / Eliminating racial and ethnic disparities in health.

Comment 02

What is your methodology for calculating the annual objectives (which change from year to year)?

Response to Comment 02: See the Attachment entitled "Development of the Annual Objectives for National Performance Measures" (included in the final version of the report/application) for a description of the methodology used to calculate the annual objectives.

Comment 03

Generally, I found the annual report to be a well-written and thorough review of existing MCAH programs and activities. However, I didn't see anything about what the plans are for 2005-2006. Is that not part of the application?

Response to Comment 03: Plans for the coming year are included in the final report/application, but not in the preliminary, abridged version. The final report/application includes 150 pages of narrative and 21 data forms. Given the volume of material and the timeline for production, it is not practical to post the entire document for public comment prior to the July 15 submission deadline. The final version of the report/application will be posted on the MCAH/OFP website in October or November. You are encouraged to review plans for the coming year at that time.

Comment 04

Regarding National Performance Measure 09, there should be a footnote about how this measure is calculated, because my recollection is that this is simply a non-weighted average of the rate of paid sealant claims in Denti-Cal and commercial Delta Dental plans, which is not really the prevalence measure described by this performance measure.

Response to Comment 04: The final report/application does contain detailed footnotes about data sources. The source of data for National Performance Measure 09 has changed since last year. The current source of data is the 2005

Oral Health Needs Assessment for Children, a survey of a representative sample of elementary schools in California.

Comment 05

It would be nice if there were more California-specific performance measures, in particular the percent of children without dental insurance (available through CHIS), the percent of children with untreated caries (available through the 2005 Oral Health Needs Assessment), and the percent of pregnant women with no dental visit in the past year (available from MIHA).

Response to Comment 05: In accordance with guidelines from HRSA (the federal Title V administrator), California reviews its state performance measures every five years. Your suggestions will be taken under advisement in the next round of updates, which will be in FY 2005-2006.

Comment 06

It would help if data infrastructure were separated as an issue in the document. It gets alluded to in various places but it is hard to understand the scope of the problem. Given the Institute of Medicine's 2004 report "Child's Health, the Nation's Wealth" as well as current concerns about continued funding of MCH block grants in Congress, it is critical that we have data systems that can track children's health and what we do. We currently have an assortment of administrative datasets (e.g. CHDP, immunization registries, vital statistics, etc) that track various pieces of a child's health. We need to move towards some type of integration and eliminate redundancies.

Response to Comment 06: HRSA (the federal Title V administrator) is very specific in its requirements for the annual Title V block grant report/application, including instructions for the content of each section. Section III F (Health Status Capacity Indicators) is the section that contains information about data infrastructure. This section describes the current patchwork of data sources, but does not address the larger question of how they could be integrated.

Comment 07

Concerning Family Centered Care, you may want to add that there was a State-County joint workshop on CCS and Family Centered Care at the 2nd Annual International Conference on Family Centered Care in San Francisco in February 2005. This was the only presentation by a government program addressing family centered care.

Response to Comment 07: This information was added to Section IVB, NPM #2.

Comment 08

You have addressed the CRISS group but not the Los Angeles Partnership for Special Needs Children, a CCS – stakeholder group whose focus last year was to increase awareness of the need to screen CCS eligible children for mental health problems and refer. This was the second year addressing this activity, following a conference in Spring 2003, “Accessing Mental Health Services for Children with Special Health Care Needs.”

Response to Comment 08: This information was added to Section IVB, NPM #5.

Comment 09

I found this document very interesting reading and felt it taught me a lot about current priorities at state level for maternal and child health services. Many physicians in California, probably the majority, have very limited knowledge of the programs operating at state level and of the areas of prioritization. This limits their ability to make best use of existing programs, and to collaborate more effectively with MCH Staff. They also lack knowledge of state goals and targets and of how their individual efforts can influence these outcome measures. I would advocate for a wider dissemination of this report, if possible, through partner agency websites, highlights in newsletters, an e-report to physicians, perhaps a short article in California Pediatrician, AAP Chapter Newsletters etc..

Similarly with the state-level programs listed on page 19, many physicians are unaware of what they do, eligibility requirements, how to utilize them, and some de-mystification of this process will be necessary if these programs are to function at maximal effectiveness. This would require a targeted education of physicians, and of medical students and residents and I would recommend partnering with institutes of education to achieve this goal.

Many of the programs described speak to an increased need for MCH staff to collaborate with other providers, and with parents and families in program implementation. The framework for achieving this type of collaboration statewide currently appears patchy. While CRISS exists in Northern California there is no real equivalent in Southern California - do we need a Southern California strategy for community and professional engagement?

Response to Comment 09: The MCAH/OFP and CMS Branches will take these comments under consideration. Regarding the lack of a program similar to CRISS in Northern California, the CMS Branch has requested the CRISS group to analyze data regarding FCC and transitioning services from around the state and not just the 14 county programs involved with CRISS. The Los Angeles Partnership for Special Needs Children has a CCS Workgroup with a Southern California focus, which meets monthly and includes participants from Regional Centers, State and Southern California County CCS programs, CCS Special Care

Centers, advocates, health plans, and the Department of Child and Family Services. They have been addressing mental health services and the medical home for CSHCNs.

Comment 10

On pg. 25, [CCS] caseloads are prevalence measures but do we have any information on the number of new users of services or the frequency of use (e.g. there may be a subset of high frequency utilizers who are generating most of the expenses & this may or may not be appropriate utilization).

Response to Comment 10: The CMS Branch has not looked at new referrals and the percentage of these referrals that are found to be CCS eligible. The Branch is going to be looking at the frequency of use of services in the future. The Branch is aware that NICU hospitalizations, organ transplants, and blood factor therapy of children with hemophilia are generating much of the expenses.

California's Response to the FFY 2005 Title V Grant Recommendations

There were no major recommendations made in the review of California's 2005 grant application and progress report. Four weaknesses/recommendations were noted, as follows.

Weakness: While issues related to budgetary constraints and reorganization were cited, a concrete plan to address the issues was not clear. An example was that site reviews could not take place but nothing was stated on what the alternative solution might be. Recommendation: Describe the plan for addressing the drastic changes taking place in the State Government with the cut back in funds for travel, equipment, etc.

Response: During FY 2004/05, MCAH/OFP and CMS Branches have worked to ensure necessary program monitoring and oversight is exercised despite ongoing budget constraints. MCAH/OFP managers used the following three precepts to develop low cost alternatives to ensure program and contract oversight is maintained.

1. Determine and implement structural changes to streamline program oversight. Specific changes include:
   - Consolidate state oversight for each local health jurisdiction's programs under one staff person per jurisdiction.
   - Maximize use of teleconferences, electronic communication and centralized meetings to provide local agencies with updated information and allow for provision of technical assistance and training to local agencies.

2. Maximize state and local staff time devoted to line program activities, minimize administrative tasks. Specific changes include:
   - Implement annual program and progress reports in lieu of semi-annual reports
   - Streamline reporting format and initiate development of database to consolidate information into efficient and effective tool for program oversight and management.

3. Maximize use of automated tools to enhance efficiency in administrative tasks. Specific changes include;
   - Enhance Contract Management Information System (CMIS) database to enable automated generation of grants and contracts.
   - Develop and implement linked budget and invoice spreadsheets for local agencies use in developing their budgets and drawing down their budget as monthly or quarterly invoices are submitted.

For the CMS Branch, local site reviews that didn't require any significant travel and could be done with smaller teams were completed during the time of the budget constraints. Some paper reviews were accomplished. More telephone conferencing occurred.

Weakness: Parent/family involvement at both state and count levels seems inadequate, although improving. Recommendation: Identify measures to increase parent involvement, including involvement with the upcoming 2005 Needs Assessment.

Response: California DHS recognizes parent, family, and community involvement as critical to the development of responsive, family centered, and community based systems of care. While this has been a long-standing state priority, MCAH/OFP and CMS are making special efforts this year, in accordance with the federal Title V Reviewers' recommendations in August 2004, to strengthen existing partnerships among families, communities and policymakers and to provide more information about those partnerships in the annual Title V application/report. For more detailed information, see Section IV B State Priorities / Parent and Community Involvement.

In addition, after this weakness was identified last year, the CMS Branch expanded the information regarding parent/family involvement in the final FFY 2005 Title V report/application in the sections on Agency Capacity (family-centered care for CSHCN) and for National Performance Measures 2 and 5.

Weakness: Reduction in FIMR represents lost opportunities to identify and address contributors to disparities. Response: In FY 2002-03 funding for the California FIMR Program was reduced by 33 percent. However, in FY 2004-05, Title V funds ($250,000) were reallocated to the local FIMR programs through the Black Infant Health / Fetal Infant Mortality Review (BIH/FIMR) enhancement project. The goal of the BIH/FIMR program is to reduce African American fetal and infant deaths through review of these deaths at the community level and ultimately to reduce or eliminate the racial/ethnic disparity in the fetal and infant mortality rates.

Weakness: Increasing motor vehicle fatality rates are of concern, especially given lack of state capacity / resources to investigate. Recommendation: Consider seeking federal assistance in analyzing and investigating motor vehicle fatality rates.

Response: The MCAH/OFP Branch, in collaboration with the San Diego State University Center for Injury Prevention Policy and Practice (CIPPP) and the Epidemiology and Prevention for Injury Control (EPIC) Branch of DHS, has applied for a California Office of Traffic Safety Grant to investigate the reasons for the recent increase in youth motor vehicle deaths, to develop teen motor vehicle death maps at the county level, and to disseminate information about best practices in decreasing youth motor vehicle deaths. The Branch expects to hear in July or August whether or not this grant application was successful.